MHSOAC
MENTAL HEALTH SERVICES
OVERSIGHT AND ACCOUNTABILITY COMMISSION

MHSOAC PREVENTION AND EARLY INTERVENTION COMMITTEE PROPOSAL

Introduction

The Mental Health Services Oversight and Accountability Commission (MHSOAC) was established in July 2005 by the Mental Health Services Act (MHSA). The MHSOAC is responsible for ensuring that MHSA funds are utilized properly throughout California. The MHSOAC created a Prevention and Early Intervention (PEI) Committee that consists of 5 MHSOAC Commissioners and 15 public members representing various mental health constituencies, including public mental health clients, family members of the children and adults using the public mental health system, service providers, the State Department of Mental Health, and the California Mental Health Directors. The Committee began meeting in January 2006 to provide to the MHSOAC with broad policy recommendations in Prevention and Early Intervention. Their objectives included:

1. Defining Prevention and Early Intervention in accord with the statute requirements
2. Identifying Prevention and Early Intervention Vision and Guiding Principles
3. Identifying Prevention and Early Intervention Program Criterion
4. Identifying Prevention and Early Intervention State and County Priority Populations

Decision Points for Mental Health Services Oversight and Accountability Commissioners to Consider

This document will refer to two specific questions that MHSOAC PEI Committee has discussed and will bring to the Commissioners for further deliberation at the September Commission meeting. These questions will be accompanied with recommendations from the PEI Committee as well as contextual information regarding points of diverging opinions within the Committee. The final vote upon the recommendations will occur at the October MHSOAC meeting. These questions are being identified at the beginning of this document to prepare Commissioners for the decision making points they will need to consider during the September meeting.

1. Should the MHSA funded Prevention and Early Intervention Program emphasize funding for individuals ages 0-25 years vs. all age groups? If so, what is the age group and what is the rationale?
2. Should the MHSA funded Prevention and Early Intervention Program emphasize funding for a specific intervention within the range of possible PEI intervention levels? If so, what priority or priorities and what is the rationale?

MHSA Prevention and Early Intervention Program Requirements

The following is a summary of MHSA statutory requirements regarding Prevention and Early Intervention Programs. Sections in bold are referenced later in this document as they provide a critical context to the MHSOAC PEI Committee's policy recommendations for the full Mental Health Services Oversight and Accountability Commission.

PART 3.6 PREVENTION AND EARLY INTERVENTION PROGRAMS

5840.

(a) The Department of Mental Health shall establish a program designed to **prevent mental illnesses from becoming severe and disabling.** The program shall emphasize improving timely access to services for underserved populations.

(b) The program shall include the following components:

1. Outreach to families, employers, primary health care providers, and others **to recognize the early signs of potentially severe and disabling mental illnesses**.
2. Access and linkage to medically necessary care provided by **county mental health programs for children with severe mental illness, as defined in Section 5600.3, and for adults and seniors with severe mental illness, as defined in Section 5600.3, as early in the onset of these conditions as practicable**.
3. **Reduction in stigma** associated with either being diagnosed with a mental illness or seeking mental health services.
4. **Reduction in discrimination** against peoples with mental illness**.**

(c) The program shall include mental health services **similar to those provided under other programs effective in preventing mental illnesses from becoming severe, and shall also include components similar to programs that have been successful in reducing the duration of untreated sever mental illness**es and assisting people in quickly regaining productive lives.

(d) The program shall emphasize strategies to **reduce the following negative outcomes** that may result from untreated mental illness:

1. **Suicide**
2. **Incarcerations**
3. **School failure or dropout**
4. **Unemployment**
5. **Prolonged suffering**
6. **Homelessness**
7. **Removal of children from their homes.**

(e) In consultation with mental health stakeholders, the department shall revise the program elements in Section 5840 applicable to all county mental health programs in future years **to reflect what is learned about the most effective prevention and intervention programs for children, adults and seniors.**

Definition of Prevention

Prevention in a mental health context, according to the Institute of Medicine, is part of a spectrum of interventions that includes prevention, treatment, and maintenance. The Institute of Medicine offers the following definitions for the three components of Prevention:

1. ***Prevention—***interventions to prevent the initial onset of a mental disorder. Three levels of prevention have been identified in the literature: universal, intended to reach all members of the community; selective, directed toward people with some risk, often based on their membership in a vulnerable subgroup; and indicated, for people identified as having the greatest risk based on specific symptoms or signs but who lack the criteria for a mental health diagnosis.
2. ***Treatment—***identification of people with mental disorders and interventions to reduce the length of time the disorder continues, stop the progression of severity, and stop the recurrence of the disorder or increase the length between episodes
3. ***Maintenance—***interventions to reduce relapse and recurrence and provide rehabilitation.

The Institute of Medicine framework is specifically oriented to mental health. While the language used is not consistent with a recovery orientation, the important point is that "prevention" in this view includes wide range of interventions potentially targeted to people with a broad spectrum of likely vulnerability. According to this approach, prevention extends from early and universal efforts directed to an entire community to prevent the initial onset of a mental disorder (for example, a supportive intervention for all new parents or all new students in middle school) through interventions with people with a defined mental disorder to reduce the risk of relapse and recurrence (for example, a consumer-run program for individuals who feel their recovery is at risk).

Older approaches evolved from a more general public health context, describing the range of prevention interventions as efforts that:

1. ***Primary Prevention:*** Protect individuals in order to avoid problems prior to signs or symptoms of problems.
2. ***Secondary Prevention:*** Identify persons in the early stages of problem behaviors and attempt through interventions to avert the ensuing negative consequences (often referred to as *early intervention).*
3. ***Tertiary Prevention:*** Strive to ameliorate negative consequences through treatment and rehabilitation.

There are growing efforts to describe prevention in positive terms. Prevention promotes positive cognitive, social, and emotional development, and encourages a state of wellbeing that allows a person to function well in the face of changing and sometimes challenging circumstances. Prevention in mental health reduces risk factors or stressors, builds skills, and increases connections and supports. The MHSA requires and inspires an approach to prevention that is integrated, accessible, culturally relevant, strength-based, effective, and that provides the best value for the money. Frameworks for prevention using the language and concepts of recovery and resilience need to be developed and disseminated.

The primary relevance of a definition of prevention is to provide a common framework for key decisions, the most fundamental of which is to specify what kinds of programs and interventions will be eligible for and prioritized under MHSA prevention funding. [1] The PEI Committee recommends the adoption of the Institute of Medicine's mental health model of prevention for purposes of defining eligible and prioritized levels of prevention to be funded by the MHSA. This recommendation leads to a decision making point to be considered by the MHSOAC:

- Include all three levels of intervention described in the Institute of Medicine model (i.e. prev., treatment, and maintenance)
- Prioritize for the first three years interventions to prevent the initial onset of a mental disorder (the "prevention" end of the spectrum) especially for people with risk factors ("indicated" and "selective" in the Institute of Medicine Framework).

[1] This is the first decision making point for the MHSOAC

A rationale to be considered when addressing the above question is that since the prevention level of intervention has received no funding in California for many years, it is an urgent need. Further, since the MHSA specifically prioritizes prevention services to "prevent mental illnesses from becoming severe and disabling," a focus on individuals with defined risk factors seems appropriate. This proposed priority is in addition to those specifically mandated by the MHSA (Section 4, Part 3.6, 5840, b, 1-4) which requires interventions to

- Reach out to people in a position to recognize the early signs of potentially severe and disabling mental illnesses
- Increase access as early as possible to necessary care for people with severe mental illness
- Reduce stigma and discrimination associated with mental illness.

Vision, Principles, Criterion, & Priority Populations

Vision Statement

Prevention and early intervention approaches are tools for empowerment and social justice that emphasize holistic and integrated approaches to mental health.

Principles and Criterion

Below are the MHSOAC PEI Committee recommendations for foundational principles and program criteria. The Committee has distinguished principles and criteria in the following way. *Principles* are values that provide guidance and inspiration, while *criteria* are standards used to make funding decisions to help ensure that prevention and early intervention efforts reflect identified principles and contribute to transforming California's mental health system.

1. **Transformational Strategies and Actions**:
   - Principle: County and state prevention and early intervention (PEI) efforts align with *transformational values* defined in recent reports such as the Mental Health Services Act, the DMH Vision and Guiding Principles of the MHSA, and the President's New Freedom Commission Report.
   - Criteria: Transformational values are to be demonstrated in county and state programs, including the following:
     i. Driven by consumers and family/caregivers
     ii. Guided by youth
     iii. Culturally and linguistically competent
     iv. Document system partnerships, community collaboration, and integration
     v. Focused on wellness, resiliency and recovery-focused
     vi. Include evidence indicating high likelihood of effectiveness and methodology to demonstrate outcomes.

2. **Leveraging Resources:**
   - Principle: County and state PEI efforts extend MHSA leadership, programs, and funding by leveraging resources (systems, networks, programs, staff) and other funding sources, including those not traditionally identified as mental health to significantly increase the total resources brought to bear to address mental health issues.
   - Criteria: In order to extend the impact of MHSA PEI funding, county and state programs demonstrate collaborations that include shared resources or other strategies to leverage additional resources beyond MHSA funds.

3. **Reduction of Disparities:**
   - Principle: County and state PEI programs shall emphasize the goal of reducing racial and cultural disparities.
   - Criteria: County and state PEI program designs use strategies demonstrated to be effective in reducing racial, ethnic, cultural, gender, economic, and other disparities in mental health services (access, quality) and outcomes.

4. **Stigma Reduction:**

   - Principle: PEI programs reduce stigma associated with mental illness and/or seeking services and supports for mental health issues.
   - Criteria:

     i. PEI efforts emphasize strategies to reduce stigma associated with mental illness.

     ii. PEI efforts demonstrate strategies to move toward a positive, non-stigmatized "help first" approach reflective of a society that recognizes its community responsibility to assist persons with mental health issues.

5. **Reduction of Discrimination**:

   - Principle: PEI efforts emphasize strategies to reduce discrimination against individuals with mental illness or mental health challenges, including limited opportunities, abuse, a various negative consequences, and barriers to recovery.
   - Criteria: PEI programs use strategies demonstrated to be effective to eliminate discrimination against persons living with mental illness and their families.

6. **Recognition of Early Signs:**

   - Principle: County and state PEI program plans shall include critical linkages with those in the best position to recognize early signs of mental illness and intervene, including parents and care givers, primary health care providers, early childhood education providers, teachers, and spiritual guides.

   - Criteria:

     iii. Counties will conduct a capacity assessment to identify the community-based providers who are currently providing mental health services and assess their capacity to provide services to the target populations. This assessment will identify provider needs and shortages as well.

     iv. The capacity assessment will assess gaps in services to determine areas of greatest need.

     v. Counties must document their efforts to identify, outreach to, and collaborate with existing community-based mental health and primary care providers.

     vi. Local PEI plans must include a description of relationships, such as partnerships, collaborations, or arrangements with other mental health and primary care providers in the community. Plans must document how

those relationships will ensure effective delivery of services and the county's ability to effectively coordinate, manage, and monitor the delivery of services.

vii. Local PEI plans must strengthen and build upon the local community-based mental health and primary care system.

viii. Prior to establishing new programs at the county level, counties must document the unavailability of effective (i.e. those with a 2 year track record of service provision; documented client satisfaction) community-based providers to serve in this capacity.

ix. Local PEI plans will be evaluated based on the ability to reach underserved communities at the earliest point of contact.

7. **Integrated and Coordinated Systems:**

- Principle: In order to extend the impact of MHSA PEI funding and make PEI services accessible to the diverse people who need them, county and state PEI program design builds integrated and coordinated systems, including linkages with systems not traditionally defined as mental health, which reflect mutually beneficial goals and combined resources to further those goals.
- Criteria:

i. County and state PEI program designs demonstrate coordination with other components of the MHSA, including community services and supports, workforce education and training, innovation, and capital improvements/technology.

ii. County and state PEI program designs demonstrate coordination with local and state initiatives.

iii. County and state PEI programs demonstrate links with and provide funding for community agencies and individuals who have established, or show capacity to establish, trusting relationships with at-risk populations, including those that have not traditionally been defined as mental health.

iv. PEI approaches emphasize comprehensive community-based, school-based, and family-based approaches.

8. **Outcomes and Effectiveness**

- Principle: County and State PEI programs will participate in the use of a statewide evaluation framework that documents meaningful, well defined, relevant, and useful outcomes that the Act seeks to obtain for individuals, families, and communities.
- Criteria:
    i. In order to maximize the effectiveness of MHSA PEI funding, county and state programs invest in optimal points of intervention or "tipping points". Optimal points of intervention are defined as those interventions targeted at a specific population and/or age group that can be substantiated by evidence that indicates the intervention has the highest probability to divert negative outcomes, and/or generate cost savings.
    ii. County and state PEI plans include well-conceived strategies to assess the effectiveness and outcomes of their programs, and reflect what is learned to all levels of the system in order to improve services and outcomes.

9. **User-Friendly Plans:**

- Principle: County and state PEI program plans will be accessible.
- Criteria: County and state PEI program requirements and ensuing plans are written in accessible lay language that allows for reasonable implementation at all levels and supports the development of culturally and linguistically relevant services.

10. **Non-Traditional Mental Health Settings:**

- Principle: County and State PEI programs shall increase the provision of culturally competent and linguistically appropriate prevention interventions in non-traditional mental health settings, i.e., school and early childhood settings, primary health care systems, and other community settings with demonstrated track records of effectively serving ethnically diverse and traditionally underserved populations.
- Criteria:
    i. Counties will conduct a capacity assessment that will identify their own capacity for serving ethnically diverse and traditionally underserved populations as well as the capacity of community-based organizations with demonstrated track records in serving these populations.

ii. The capacity assessment will assess gaps in services to determine areas of greatest need.
iii. Counties must document their efforts to identify, outreach to and collaborate with existing community-based mental health and primary care providers.
iv. Local PEI plans must include a description of relationships, such as partnerships, collaborations, or arrangements with other mental health and primary care providers in the community. Plans must document how those relationships will ensure effective delivery of services and the county's ability to effectively coordinate, manage, and monitor the delivery of services.
v. Local PEI plans must strengthen and build upon the local community-based mental health and primary care system, including community clinics and health centers.
vi. Prior to establishing new programs at the county level, counties must document the unavailability of community-based providers to serve in this capacity.
vii. Counties shall include in their provider network community-based organizations that meet the identified needs of consumers.
viii. Local PEI plans will be evaluated based on the ability to reach underserved communities at the earliest point of contact and in a manner that seeks to address specific barriers to access faced by underserved communities, including cultural and linguistic barriers.

11. **Prioritizing PEI Efforts by Age** [2]

- Principle, Option One: PEI programs have no an initial funding emphasis based on age group, in order to provide prevention and early intervention services for the range of population who needs and can benefit from such services.
- Criteria, Option One: PEI programs will design a PEI program that serves the entire age range of the population.

- Principle, Option Two: PEI programs have an initial funding emphasis on a children, youth, adolescents, and transition age youth (ages 0-25) and their families in order to focus resources and make strong initial impact in a high-priority area.
- Criteria, Option Two: PEI programs will, as a priority for X% of funding, target children, youth, adolescents, and transition age youth (ages 0 through 25 years) and their families

[2] Please note this the second decision making point for the MHSOAC

Priority Populations

Below are the priority populations defined by the MHSOAC PEI Committee. Counties will design programs specifically for the populations defined below. Populations are organized according to age. If Statewide programs are approved, they will focus on the issues listed under Statewide Topics below.

COUNTY POPULATIONS
A. Children & Youth, Ages 0-25, and their Families
Children and youth at risk of entering the juvenile justice system
Children and youth at risk of entering or in the foster care system
Children and youth at risk of school failure
Infants and very young children with risk factors (focused is on supporting positive relationships with parents/caregivers and support for child care providers)
Children and youth "first break" (initial episode of a severe mental illness)
Children, youth, and their families that are homeless
Children and youth whose parents/caregivers have or are at risk for mental illness
Children and youth who are survivors of trauma
Children and youth from ethnic and racially diverse communities where research demonstrates they are at risk for specific mental health disorders (for example, Latinas at risk for depression & suicide)

B. ADULTS AND OLDER ADULTS
Adults and older adults at “first break” (initial episode of a severe mental illness)
Adults and older adults and their families that are homeless
Adults and older adults that are parents/caregivers and who have/are at risk for mental illness
Adults and older adults who are survivors of trauma
Adults and older adults at risk for unemployment
Adults and older adults who are at risk for or are already incarcerated
Adults and older adults at risk of school failure
Adults and older adults from ethnic and racially diverse communities where research demonstrates they are at risk for specific mental health disorders
STATEWIDE TOPICS
A. ACROSS ALL AGES
Stigma Reduction
Discrimination Reduction
Suicide Reduction

References

U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General* Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999.